

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05255

4136

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 10, 11, 12, 13, 14 Film Q215 5-14-57 at Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 476-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gorman Road		d. STREET ADDRESS 4609 E. Capitol St.	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Anderson		4. DATE OF DEATH Month April Day 29 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 34 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clinton Peace		14. MOTHER'S MAIDEN NAME Henrietta Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic alcoholism 322.1 DEMO Fatty liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DEMO Early bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 4/29/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried May 8-1957		Washington	Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W. D. Bacon		24a. REC'D BY REGISTRAR 9	
ADDRESS 1722 7-5-57		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
JAMES H. HODGINS		45		Male		White		April 10, 1957	
Place of Birth		City of Birth		County of Birth		State of Birth		Date of Birth	
Boston		Boston		Suffolk		Massachusetts		April 10, 1912	
Occupation		Cause of Death		Manner of Death		Place of Death		Date of Death	
Police Officer		Myocardial Infarction		Natural		Home		April 10, 1957	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

Chronic Alcoholism
Fatty Liver
Early Myocardial Infarction

RECEIVED
MAY 9 1957
BUREAU V. 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4137

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 12 Film G215 5-17-57 et.

04143

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Howard Highland SIMPSONVILLE				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1205 E. Federal St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ludwig Middle Louis Last Bierau				4. DATE OF DEATH Month April Day 16 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-1877	9. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ludwig Bierau				14. MOTHER'S MAIDEN NAME Marie Arnold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-8064		17. INFORMANT Mrs. Juanita Mc Intosh, Simpsonville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 928.1 DUE TO Severe crushing injury to anterior chest wall by ram (sheep) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) by ram (sheep) DUE TO (c) by ram (sheep) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour 1 1/2 hour						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mutiple contusions face, fracture right tibia & fibula below knee							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Butted and stamped by angry ram (sheep)					
20c. TIME OF INJURY Month, Day, Year 6:00 p.m. 4/16 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	20f. (City or town) (County) (State) Simpsonville, Howard, Maryland				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles S. Whitaker		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/17/57			
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 4-18-57		22b. NAME OF CEMETERY OR CREMATORY GREENMOUNT		22d. LOCATION (City, town, or county) (State) BALTO. Md			
23. FUNERAL DIRECTOR'S SIGNATURE John Bradley, Rockville, Md		ADDRESS Rockville, Md		24a. REC'D BY REGISTRAR APR 22 1957		24b. REGISTRAR'S SIGNATURE Marie Whitaker	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04144

Reg. Dist. No.

191

4138

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 29				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills 03x12 d. STREET ADDRESS Park Heights Ave. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CISSEL GAMBRILL BROWN				4. DATE OF DEATH Month Day Year April 25, 1957 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1912	
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Dallas Brown				14. MOTHER'S MAIDEN NAME Mollie Krah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-8085		17. INFORMANT Address Mary Brown, Owings Mills, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocuted DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Standing on load of bailed hay and came in contact with electric						INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Standing on load of bailed hay and came in contact with electric					
20c. TIME OF INJURY Month, Day, Year 11.30 AM 4-25-57 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) Ellicott City Howard Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George E. Burtorg EXAMINER'S NAME (Type) George E. Burtorg M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-26-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-57		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR APR 29 1957		24b. REGISTRAR'S SIGNATURE J. E. Laughery	

MEDICAL CERTIFICATION

13

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MAZLAND STATE DEPARTMENT OF HEALTH - BATHMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1138

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

Amount of loss of feeling legs and arms in contact with electric wire

BUREAU V. 3

APR 29 1957

RECEIVED

4139

CERTIFICATE OF DEATH

Reg. Dist. No.

041145

1. PLACE OF DEATH a. COUNTY MARYLAND Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 XXXXXX Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 Fells Ave				d. STREET ADDRESS 155 Fells Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARTHA Middle ELIZABETH Last CAVEY				4. DATE OF DEATH Month April Day 19 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 14, 1896	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 19 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick, Md		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Katie Krieder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-8205		17. INFORMANT Walter Cavey, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH instant		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 57 to 4-19 , 19 57 , that I last saw the deceased alive on 4-19 , 19 57 , and that death occurred at CA M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Burget		M.D. Ellicott City, Md		ADDRESS (Street, city or town, state) Ellicott City, Md		DATE SIGNED 4-19-57	
PHYSICIAN'S NAME (Type) GEORGE E. BURGETT M.D. ELICOTT CITY, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-22-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR APR 22 1957		24b. REGISTRAR'S SIGNATURE J.E. Loughran	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES J. JAMES		45		M		W		C	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
APR 22 1957		HOSPITAL		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
TIME OF DEATH		PLACE OF BIRTH		DATE OF BIRTH		PLACE OF BIRTH		EDUCATION	
10:00 AM		MASSACHUSETTS		APR 22 1912		MASSACHUSETTS		HIGH SCHOOL	
OCCUPATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
FARMER		MARRIED		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF REGISTRAR		NAME OF CLERK		NAME OF CLERK		NAME OF CLERK	
JAMES J. JAMES		JAMES J. JAMES		JAMES J. JAMES		JAMES J. JAMES		JAMES J. JAMES	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	

RECEIVED
APR 22 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **0414690**

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge (Harwood)		c. LENGTH OF STAY IN 1b X2 (Harwood)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2101 Hawthorn Ave.		d. STREET ADDRESS 2101 Hawthorn Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE W. CLARKE		4. DATE OF DEATH Month Day Year April 6, 1957 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1903
9. AGE (In years last birthday) yrs. 53		IF UNDER 1 YEAR Months Days Hours Min. 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Woolen Mill	
11. BIRTHPLACE (State or foreign country) Petersburg, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W. Clarke		14. MOTHER'S MAIDEN NAME Lydia Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-3624	
17. INFORMANT Grace I. Clarke, Elkridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X Bronchogenic Carcinoma DUE TO (b) General Carcinomatosis DUE TO (c) 3 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 8 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1956 , to Apr 6, 1957 , that I last saw the deceased alive on Apr 26, 1957 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B B Brumbaugh M.D.		ADDRESS (Street, city or town, state) 316 09 Main St	
DATE SIGNED 4/7/57			
PHYSICIAN'S NAME (Type) B B Brumbaugh		Elkridge 27 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-57	
22c. NAME OF CEMETERY OR CREMATORY Blandford		22d. LOCATION (City, town, or county) (State) Petersburg, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		ADDRESS	
24a. REC'D BY REGISTRAR APR 9 1957		24b. REGISTRAR'S SIGNATURE E. Bird Williams	

RECEIVED

4141
CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH o. COUNTY <u>Howard County</u> <u>Elkridge</u> <u>Howard Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge Md</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1111 Montgomery Rd.</u>		d. STREET ADDRESS <u>1111 Montgomery Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>Stewart</u> Last <u>COLE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 19-1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Edward Spranklin</u>		14. MOTHER'S MAIDEN NAME <u>Elnora Calk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Thomas Spranklin</u>		Address <u>1111 Montgomery Rd. Elkridge Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> <u>592X</u> DUE TO <u>right sided hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Glomerular nephritis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>54 years</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>duodenal ulcer</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> 19 <u>48</u> , to <u>April</u> 19 <u>57</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>57</u> , and that death occurred at <u>6:00 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Wilbur Stewart</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>6 E. Read St. Baltimore</u> <u>4/13/57</u>	
PHYSICIAN'S NAME (Type) <u>C. Wilbur Stewart</u>		<u>6 E. Read St.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	22b. DATE THEREOF <u>4/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Maus.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. J. Tichenor & Sons - Balto 17 Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Edith Williams</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05258

Reg. Dist. No. 191

4142

1. PLACE OF DEATH a. COUNTY Howard MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Merriman St.				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Merriman St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First HEMSON Middle DORSEY Last				4. DATE OF DEATH Month April Day 27 Year 19 57											
5. SEX Male		6. COLOR OR RACE Unblond		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1896		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Howard Co. Md				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery occlusion DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH instant. instant.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE Charles S. Whitaker M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/27/57					
EXAMINER'S NAME (Type) CHARLES S. WHITAKER						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 5-13-57				22c. NAME OF CEMETERY OR CREMATORY U. S. Med. School				22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D BY REGISTRAR DATE 5/14/57				24b. REGISTRAR'S SIGNATURE John B. Laughman					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

1957 15

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4143

CERTIFICATE OF DEATH

Reg. Dist. No.

04148

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vineyard Road				d. STREET ADDRESS Vineyard Road			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HARRY W. LORD				4. DATE OF DEATH Month Day Year April 11, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm owner		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Luther Lord				14. MOTHER'S MAIDEN NAME Mary Warner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mrs. Ernest German, Mt. Airy, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with chronic mto-} DUE TO cardial failure (c) _____						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 11 , 19 57 , to April 11 , 19 57 , that I last saw the deceased alive on April 2 , 19 57 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED ACTUAL SIGNATURE Charles S. Whitaker, M.D. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Louis		22d. LOCATION (City, town, or county) (State) Clarksville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR APR 18 1957		24b. REGISTRAR'S SIGNATURE J. E. Longhans	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist		Signature of Pharmacist		Signature of Nurse		Signature of Midwife		Signature of Other	
John Doe		Male		45		Jan 1, 1912		New York City		New York City		Heart Disease		Jan 15, 1957		10:00 AM		Home		Natural		J. Smith, M.D.		J. Doe, Registrar		J. Doe, Informant		J. Doe, Coroner		J. Doe, Medical Examiner		J. Doe, Pathologist		J. Doe, Anatomist		J. Doe, Surgeon		J. Doe, Dentist		J. Doe, Pharmacist		J. Doe, Nurse		J. Doe, Midwife		J. Doe, Other	

BUREAU V. S.

APR 18 1957

RECEIVED

4144

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Trotter Road</u>		d. STREET ADDRESS <u>Trotter Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>MATTHEWS</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1876</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>81</u> Days <u>16</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mech. Engr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>London, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>England</u> ✓	
13. FATHER'S NAME <u>James Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Lane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>077-05-9144</u>	
17. INFORMANT <u>Robert Clark, Clarksville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma of urinary bladder with metastases</u> DUE TO <u>Brain and liver</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>55</u> , to <u>April 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 15</u> , 19 <u>57</u> , and that death occurred at <u>3:05 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u>		ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>		DATE SIGNED <u>4/17/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4-19-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md.</u>		24a. REC'D BY REGISTRAR <u>4/17/57</u>	
ADDRESS <u>Ellicott City, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Marie Whitaker</u>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4145

CERTIFICATE OF DEATH

Reg. Dist. No.

04150

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b X2 Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rogers Ave.				d. STREET ADDRESS 1 Rogers Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM THOMAS RADCLIFFE				4. DATE OF DEATH Month Day Year April 16 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 7, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY House painter		11. BIRTHPLACE (State or foreign country) Ellicott City, Md	
12. CITIZEN OF WHAT COUNTRY? Painter							
13. FATHER'S NAME Samuel Eugene Radcliffe				14. MOTHER'S MAIDEN NAME Addie Cassidy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 218-01-8664		17. INFORMANT Mrs. C. Emma Radcliffe, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-28 , 19 56 , to 4-16 , 19 57 , that I last saw the deceased alive on 4-16 , 19 57 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Burgtorf				ADDRESS (Street, city or town, state) Ellicott City, Md.			
DATE SIGNED 4-17-57							
PHYSICIAN'S NAME (Type) GEORGE E. BURGTORF Md.				ELLICOTT CITY Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-20-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR APR 22 1957		24b. REGISTRAR'S SIGNATURE J. E. Laughery	

APR 22 1957

RECEIVED

4146

CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <u>Howard Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Peffer Corner</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Peffer Corner</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		d. STREET ADDRESS <u>Waterloo Rd</u>	
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First <u>RENN</u> Middle <u>REN</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 23, 1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Basler</u>		14. MOTHER'S MAIDEN NAME <u>Roeder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs E. M. Coan</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY INSUFFICIENCY</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 13, 1955</u> , to <u>April 24, 1957</u> , that I last saw the deceased alive on <u>March 29, 1957</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Donald E. Fisher</u> M.D.		DATE SIGNED <u>April 25, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Donald E. Fisher, M.D.,</u>		<u>101 Columbia Road, Ellicott City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 27</u>	<u>London Park</u>	<u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>Mac Holt + Son Catonsville</u>		DATE <u>APR 29 1957</u>	<u>E. Bird Williams</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 29 1957

RECEIVED

4147

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b Ellicott City d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Annapolis Road				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Old Annapolis Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BRADEN S RUSSELL				4. DATE OF DEATH Month Day Year April 18, 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1885	
9. AGE (In years last birthday) yrs. 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis Russell				14. MOTHER'S MAIDEN NAME Jenette Wanawitch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address William Hatfield, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Decompensation DUE TO (c) AS CVD						INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 YR NOT KNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Ellicott City, Md.				20g. (County) Howard		20h. (State) Md.	
21. I certify that I attended the deceased from 3-30 , 19 57 , to 4-18 , 19 57 , that I last saw the deceased alive on 3-30 , 19 57 , and that death occurred at 11:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) COLUMBIA RD ELLICOTT CITY, MD. DATE SIGNED 4-19-57							
ACTUAL SIGNATURE P. V. Thorpe				PHYSICIAN'S NAME (Type) PETER V. THORPE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-19-1957		22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Martinsburg, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR ADD 22 1057		24b. REGISTRAR'S SIGNATURE J. E. Loughran	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4148

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hilmar Middle F. Last Sommers		4. DATE OF DEATH Month April Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/81
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist-retired		10b. KIND OF BUSINESS OR INDUSTRY Dentistry	
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Hilmar F. Sommers, Jr.		Address 178 Alegria Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Uremia (c) Arteriosclerotic Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 6 months 1 year years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain disease due to cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 26 , 19 56 , to April 2 , 19 57 , that I last saw the deceased alive on April 2 , 19 57 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving J. Taylor M.D. Taylor Manor Hospital 4/2/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D. Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/5/57	
22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 4-9-57		24b. REGISTRAR'S SIGNATURE John B. Loughran P. B. E. E.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED HOMER		AGE 25		SEX Male		RACE White	
DATE OF DEATH April 12, 1957		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION None		EDUCATION High School		MARRIAGE Married		SPOUSE None	
CAUSE OF DEATH Chronic brain disease due to cerebral arteriosclerosis		MANNER OF DEATH Natural		IMMEDIATE CAUSE Stroke		INTERMEDIATE CAUSE Hypertension	
PREVIOUS ILLNESS Hypertension		PREVIOUS SURGERY None		PREVIOUS TRAUMA None		PREVIOUS DRUGS None	
SIGNATURE OF PHYSICIAN Dr. William J. ...		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF CORONER None	
DATE OF SIGNATURE April 12, 1957		PLACE OF SIGNATURE Home		CITY Baltimore		COUNTY Baltimore	
NAME OF PHYSICIAN Dr. William J. ...		NAME OF DECEASED HOMER		NAME OF WITNESS None		NAME OF CORONER None	
DATE OF SIGNATURE April 12, 1957		PLACE OF SIGNATURE Home		CITY Baltimore		COUNTY Baltimore	

RECEIVED
APR 12 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04154

4149

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Ridge Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Ridge Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Barnes Road</u>		d. STREET ADDRESS <u>Barnes Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Herbert</u> Last <u>Sunder</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Sunder</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Clarence Sunder, Laurel Md</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Death</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF DEATH Hour <u>2:00</u> min. <u>4:24</u> p. m. <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>57 Jan</u> to <u>57 April</u> , that I lost saw the deceased alive on <u>4/24</u> 19 <u>57</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D.		ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>4/24/57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 27, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem.</u>	22d. LOCATION (City, town, or county) <u>Scaggville Md</u> (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Handman, Laurel Md</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u> DATE <u>APR 30 57</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John P. Smith</i></p>		<p>2. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p>	
<p>3. DATE OF DEATH <i>April 28, 1957</i></p>		<p>4. TIME OF DEATH <i>10:15 AM</i></p>	
<p>5. PLACE OF DEATH <i>Home</i></p>		<p>6. STREET ADDRESS <i>1234 Main St.</i></p>	
<p>7. CITY <i>Baltimore</i></p>		<p>8. STATE <i>Md.</i></p>	
<p>9. ZIP CODE <i>21201</i></p>		<p>10. COUNTY <i>Baltimore</i></p>	
<p>11. MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED</p>		<p>12. OCCUPATION <i>Engineer</i></p>	
<p>13. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>14. MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE</p>	
<p>15. SIGNATURE OF PHYSICIAN <i>John P. Smith</i></p>		<p>16. SIGNATURE OF REGISTRAR <i>John P. Smith</i></p>	

BUREAU V. S.

APR 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Items 13, 14 Film G214 4-18-57 et

Reg. Dist. No.

04155

190

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		d. STREET ADDRESS One Spot	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) One Spot				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elijah Middle Clay Last Thigpen				4. DATE OF DEATH Month April Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1892		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alexander Thigpen				14. MOTHER'S MAIDEN NAME Nannie Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 182-09-0152		17. INFORMANT Willabell Thigpen, Jessups, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 30 minutes 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George E. Burgtorf M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George E. Burgtorf M D				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 9, 1957			
22a. BURIAL, CREMATION, REMOVAL, or other disposition		22b. DATE THEREOF 4-13-57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) 4001 Suitland Rd., Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Schey Inc				ADDRESS 424 "R" St. N. W. Wash.		24. REG'D. BY REGISTRAR APR 15 1957	
				24b. REGISTRAR'S SIGNATURE E. Bird Williams			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1150

BUREAU V. S.

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4151
CERTIFICATE OF DEATH

04156
191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>Ellicott City</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffers Nursing Home</u>		d. STREET ADDRESS <u>Rogers Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA MAY TUCKER</u>		4. DATE OF DEATH Month Day Year <u>April 3 1957</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 16, 1879</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodbine, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Toney</u>		14. MOTHER'S MAIDEN NAME <u>Alice V. Pickett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-20-5039</u>	
17. INFORMANT <u>James Tucker, Ellicott City, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>54</u> to <u>4-3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-3</u> , 19 <u>57</u> , and that death occurred at <u>10 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Burgtorf</u> M.D.		ADDRESS (Street, city or town, state) <u>Ellicott City, Md</u>	
DATE SIGNED <u>4-4-57</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE E. BURGTORF</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Higinbotham, Ellicott City, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 8 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. E. Lougherans</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 19 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES OF AMERICA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		CONDUCTOR		HEART DISEASE		NATURAL	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE		MARYLAND		UNITED STATES OF AMERICA		APR 4 1968		11:00 AM		11:00		00	
PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT		COUNTRY OF INTERMENT		DATE OF INTERMENT		TIME OF INTERMENT		HOURS OF INTERMENT		MINUTES OF INTERMENT	
FARMER'S BURIAL HOME		BALTIMORE		MARYLAND		UNITED STATES OF AMERICA		APR 6 1968		10:00 AM		10:00		00	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF MORTUARY		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF CHURCH		NAME OF MINISTERS	
DR. J. H. BROWN		DR. J. H. BROWN		DR. J. H. BROWN		J. H. BROWN		J. H. BROWN		FARMER'S BURIAL HOME		FARMER'S BURIAL HOME		FARMER'S BURIAL HOME	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF PATHOLOGIST		SIGNATURE OF MORTUARY		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY		SIGNATURE OF CHURCH		SIGNATURE OF MINISTERS	
J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 6 1968		APR 6 1968		APR 6 1968		APR 6 1968		APR 6 1968		APR 6 1968		APR 6 1968		APR 6 1968	

BUREAU V. 3

APR 8 1967

RECEIVED

4152

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <u>Balto. HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highland Manor</u>				d. STREET ADDRESS <u>1414 Eutaw Place</u>			
3. NAME OF DECEASED (Type or print) First <u>CLOYD</u> Middle <u>Van</u> Last <u>ATTA</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>212-07-5771</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u> <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/5</u> , 19 <u>57</u> , to <u>4/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/19</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>46 Church St, Ellicott City, Md.</u> DATE SIGNED <u>4/24/57</u>							
ACTUAL SIGNATURE <u>Thomas B. Herbert</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Thomas B. Herbert</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 24, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Sons - Balt.</u>				24a. REC'D BY REGISTRAR DATE <u>4-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Laughery</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4153

CERTIFICATE OF DEATH

04158

Reg. Dist. No.

192

1. PLACE OF DEATH a. COUNTY <u>Howard Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariettaville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariettaville Md x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sand Hill Rd</u>				d. STREET ADDRESS <u>Sand Hill Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Sedonie</u> First <u>Whittaker</u> Middle <u>W</u> Last <u>H</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>2</u> - Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug-24-1939</u>	
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS, OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Solomon Whittaker</u>				14. MOTHER'S MAIDEN NAME <u>Gladys Cummings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Solomon Whittaker</u> Address <u>Sand Hill Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>174x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Cancer of the Uterus</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>5 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/16/57</u> , 19 <u>57</u> , to <u>4/2/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/2/57</u> , 19 <u>57</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Winters Lane, Balto. 28</u> DATE SIGNED <u>4/2/57</u>							
ACTUAL SIGNATURE <u>C.F. Maloney</u>				M.D. <u>57 Winters Lane, Balto. 28</u> DATE SIGNED <u>4/2/57</u>			
PHYSICIAN'S NAME (Type) <u>C.F. Maloney, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cme</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O Wilson</u> ADDRESS <u>1090 Brandon Ave</u>				24a. REC'D BY REGISTRAR <u>4/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>Alice Kelly</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	